Medicare Supplemental Insurance in Massachusetts: Current Trends

Michael Miller, M.P.P.

Gerontology Institute
University of Massachusetts Boston
January 1998

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EXECUTIVE SUMMARY

Medicare Supplemental Insurance (Medigap) is insurance that thousands of elderly and disabled people purchase to fill in some of the gaps in coverage left by the Medicare program. In 1992, Health Care For All prepared a report for the Gerontology Institute at the University of Massachusetts Boston on the Medigap market -- *Medicare Supplemental Insurance: Today's Crisis*. That report found that rapid increases in premiums were forcing an increasing number of elders to do without such coverage. As a result, a large number of elders faced significant financial exposure for the cost of medical care not covered by Medicare.

Since the earlier report, the Medigap market in Massachusetts has changed significantly in several ways. First, Massachusetts law governing Medigap has been amended. In 1992, the only insurer required to accept all applicants for Medigap insurance regardless of health status was Blue Cross/Blue Shield. Today, all insurers in the Medigap market must accept all eligible applicants during an annual open enrollment. Second, after years of sluggish growth, enrollment in Medicare Health Maintenance Organizations (HMOs) has taken off. In addition, in 1996, the Massachusetts Legislature adopted a prescription drug subsidy program for low-income elders on Medicare. This report examines to what extent these changes have addressed the problems identified in 1992.

The key findings in this report are:

1) The cost of Medigap coverage is continuing to spiral upwards, in spite of recent state reforms in the Medigap market.

2) The percentage of elders with Medigap coverage is declining even though no-cost Medicare HMOs are on the market.

3) Most HMO enrollment growth appears to be drawn from the fee-for-service market rather than from previously uninsured elders.

4) HMOs give elders a more affordable option than traditional Medigap insurance, but, as is the case with the fee-for-service plans, healthier and sicker elders in HMOs appear to be dividing into separate pools. This separation of healthy and sick elders in HMOs is likely to undermine affordable comprehensive HMO coverage.

5) Without additional public policy intervention, comprehensive Medigap policies will not be affordable for all but the wealthiest elders. As a result, many elders will face high out-of-pocket costs because of gaps in their Medicare coverage.

This report recommends policy directives that may help alleviate some of the problems facing Medigap. The best solution would be to combine elders and young adults into one plan with premiums based on income. Other alternative include the following:

- On the federal level, the government could allow Medicare to pick up its fair share of outpatient costs. Another recommendation the report proposes would adjust the payment formula to Medicare HMOs, better accounting for enrollee risk and thus reducing selection issues between fee-for-service and HMO plans.

- On the state level, Massachusetts could apply some level of risk adjustment to the Medigap market. This would reduce the current problem of healthy and sick elders joining separate plans. Another option would require prescription coverage for all Medigap plans. This could be achieved by allowing Medigap plans to work in tandem with the state's prescription drug subsidy program.

The report concludes by emphasizing the widening gap between the cost of health care services and the percentage of that cost that Medicare covers. The report warns that if this trend continues, the Medigap insurance market could break down, resulting in an increase in the number of elders who lack comprehensive coverage. In order to prevent this from occurring, a combination of political leadership and a high degree of unity and mobilization within the elder community is necessary.

INTRODUCTION

This report serves as a follow-up to a report, *Medicare Supplemental Insurance: Today's Crisis*, prepared in 1992 for the Gerontology Institute at the University of Massachusetts Boston by Health Care For All. It analyzes the changing face of the Medigap market, which is made up of indemnity and HMO insurance plans created to fill the gaps in coverage that exist in the federal Medicare program.

The report begins with an introduction to the Medicare system, particularly focusing on how Medigap plans interact with Medicare. It identifies the gaps in Medicare coverage that are faced by all Medicare beneficiaries and sorts through the different types of plans offered by fee-for-service insurers and HMOs.

The report continues by analyzing changes in the Medigap market since the beginning of the 1990s. It identifies a dramatic growth in the enrollment in Medigap HMOs, but cautions that this does not necessarily correlate with a dramatic growth in overall Medigap enrollment. The report shows that, in fact, after accounting for the increase in Medicare enrollees (and thus the number of people eligible to purchase Medigap) and the negative growth in indemnity Medigap plans, the percentage of elders in Massachusetts who purchase Medigap insurance has actually dropped by approximately 10% over the past seven years. This leads to an in-depth discussion about the pros and cons of the entrance of Medicare HMOs to the Medigap market.

Massachusetts's Medigap Reform Law, Chapter 176K, is analyzed in the report. The important provisions of the law are described in detail: guaranteed issue, community rating, standardized plans, minimum loss rations, rate hearings, open enrollment, restricted withdrawal from the market, and public hearings. The successes and shortcomings of the reforms are also analyzed and discussed, especially as they relate to halting the "death spiral" that has plagued and could destroy the Medigap market, which will be discussed later.

A section about enrollment and cost trends uses a series of graphs to show how Medigap has changed since 1990. Most obvious is a significant decline in enrollment in the most comprehensive "Medex Gold" plans. Other graphs show the shift among Medex enrollees from Gold to less comprehensive Bronze, the overall shift in enrollment away from Medex plans and towards HMOs, and the change in enrollment compared to the change in the Consumer Price Index.

The final phase of the report opens with an examination of the new pharmacy assistance program, which began in 1996. Its strengths and its weaknesses are discussed, as well as ways to improve the program in coming years. Possible federal changes to Medicare and Medigap, such as a move to a

voucher program or towards Medical Savings Accounts, and state options for change are also explored in this section.

The report concludes by offering possible solutions to the crisis facing the Medigap marketplace, such as a cost-sharing plan to expand the pharmacy program, or changes that would improve the monitoring of the Medigap market. The report states that, ultimately, the best solution to the problems facing Medigap would be to combine elders and younger people into one plan with premiums based on income.

(A reference list is included at the back as well as a glossary of the terms used throughout the report.)

WHAT IS MEDIGAP?

Medigap insurance is health insurance offered by various private insurers, which supplements the federal Medicare Program. The Medicare Program is a health insurance program that pays for a portion of specified medical services for people over age 65 as well as certain disabled individuals. It is a program of the U.S. Department of Health and Human Services and is administered by the Health Care Financing Administration. According to data from the Health Care Financing Administration, there were 970,845 Medicare enrollees in Massachusetts as of March 1997.

The Medicare Program began in 1965. It is divided into two parts. Hospital Insurance, or HI (also known as Medicare Part A), covers inpatient hospital costs, limited stays in a skilled nursing facility, and home health care. It is funded through a 1.45% payroll tax on both employers and employees. For most people, there is no individual premium for Part A. The Trustees of the Part A trust fund have reported that the fund will face bankruptcy by the year 2001. This finding has become the pretext for a broad discussion on reshaping the Medicare program, which could have a dramatic impact on the Medigap market.

Supplemental Medical Insurance or SMI (also known as Part B) covers 80% of physicians' and other outpatient bills. Twenty-five percent of the funding for Part B comes from premiums paid by Medicare recipients. In 1997, the Part B premium was $43.80 per month. The remaining funds for Part B come from federal general revenue. As with Part A, significant federal changes are being contemplated in Part B, primarily because, as one of the largest areas of the budget, Part B is an attractive target for current federal efforts to balance the budget.

Medicare does not cover all of the services or costs associated with the health care needs of the elderly. Routine services, including physicals, and tests for vision and hearing, are not covered by the Medicare program (although they are frequently covered by Medicare HMOs, see below). Outpatient prescription drugs are also not covered, and represent a large and rapidly growing portion of the cost of Medicare Supplemental Insurance. Although payments for skilled nursing facilities and home health have increased recently, long-term nursing home stays and extended home health care are not covered except under very limited circumstances.

Additionally, both Medicare Part A and Part B have deductibles, or minimum out-of-pocket costs that must be incurred by the enrollee before the benefits of the program begin. Currently, the first-day hospital deductible under part A is $760 and the Part B deductible is $100. Hospital co-payments for extended hospital stays (beyond 60 days) and the 20% part B coinsurance are also the responsibility of the Medicare beneficiary.

In order to address these many expensive "gaps" in Medicare coverage, supplemental insurance products designed for individuals enrolled in both parts of the Medicare program have been developed. Collectively, various Medicare Supplemental Insurance products are referred to as "Medigap" insurance.

WHAT DOES MEDIGAP INSURANCE COVER?

Medigap insurance generally covers some combination of Medicare deductibles, hospital co-payments, and Part B coinsurance. Certain policies may also include coverage for services that Medicare does not cover at all, such as prescription drugs.

As part of an effort to stem marketing abuses, in 1990 Congress ordered the standardization of Medigap policies. Nationally, there are 10 standard Medigap packages. Massachusetts had previously standardized its Medigap plans, offering six standard packages. Due to low enrollment in several plans, the number of packages available in Massachusetts was reduced to three in 1994.

The standard Medigap packages in Massachusetts are Medicare Core, Medicare Supplement One, and Medicare Supplement Two. The Blue Cross equivalents to Supplements One and Two are Medex Bronze and Medex Gold. Core only covers Medicare coinsurance payments for hospitals and physicians. It does not cover deductibles, skilled nursing coinsurance, or cover any benefits for which Medicare itself pays nothing (e.g., prescription drugs). Supplements One and Two both cover deductibles as well as coinsurance. They are identical except that Supplement Two includes prescription drug coverage. The prescription benefit includes a $35 per quarter deductible and 100% reimbursement for generic drugs, or 80% for brand-name drugs (see the following chart).

Table 1. Overview of Massachusetts Fee-For-Service Medigap Package Coverage.

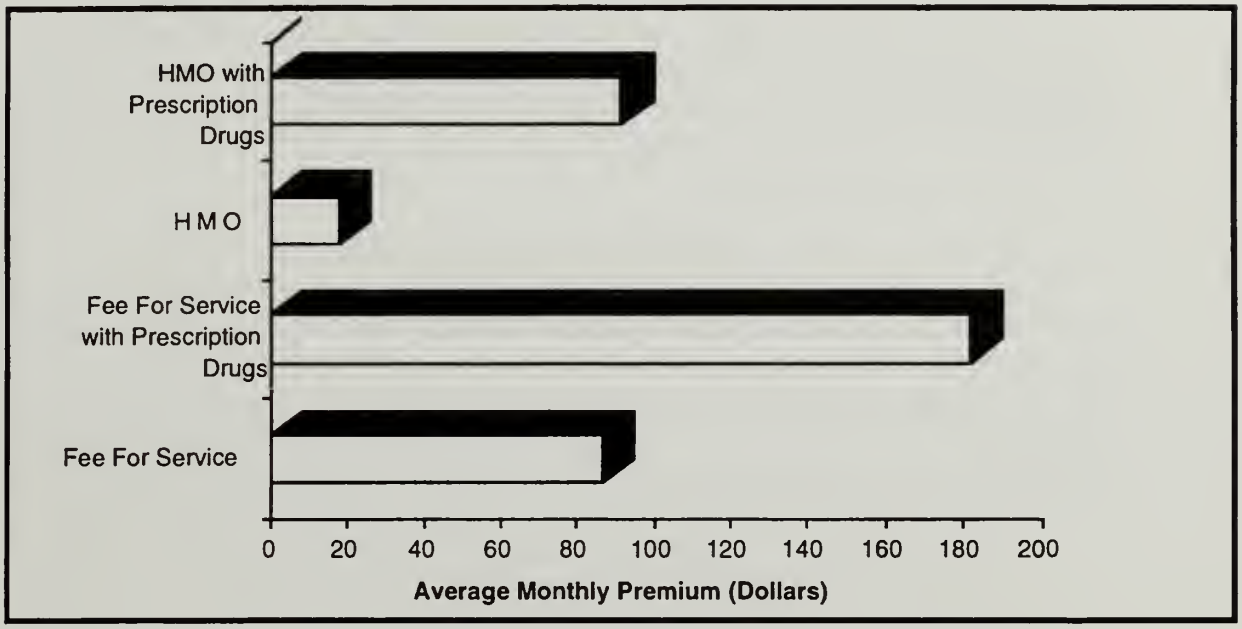
Benefit	Core	Supplement 1	Supplement 2
Hospital Deductible	No	Yes	Yes
Hospital Coinsurance	Yes	Yes	Yes
Part B Deductible	No	Yes	Yes
Part B Coinsurance	Yes	Yes	Yes
Skilled Nursing Facility Coinsurance	No	Yes	Yes
Prescription Drugs	No	No	Yes

It is important to remember that no Medigap policy covers all of the gaps in the Medicare program and that Medigap will not pay anything for medical

services denied by Medicare. Seniors with Medigap policies can still have significant out-of-pocket expenses.

WHY COST CONTAINMENT IS DIFFICULT IN THE MEDIGAP MARKET

Figure 1. Monthly Premiums for Different Plans.



The problem of keeping health care costs affordable is one that is present in all health insurance sectors, public and private. The challenge in Medigap is particularly acute since the Medigap market combines some of the problems of the private sector with those of Medicare. For example, private insurance covers little in the way of home health care or care in a skilled nursing facility, two fast-growing areas of Medicare cost. The copayments for these services are reflected in Medigap premium rates. As Medicare's cost for home health care and skilled nursing care increases, so, too, do Medigap premiums. On the other hand, Medicare does not cover prescription drugs, one of the fastest growing portions of private insurance coverage, but many Medigap plans do. In other words, with respect to cost containment, Medigap insurance must deal with increased cost for the services that Medicare does and does not cover.

Also, unlike most private insurance, it is difficult for Medigap plans to realize great savings from lowering the prices of services, one of the main strategies used by HMOs to reduce costs. Medicare pays only 89 cents on the dollar for hospital care (compared to $1.29 on the dollar in the private sector) and 38% less than private insurers for physician services (Moon and Zuckerman

1995). HMOs do have a cost advantage compared to traditional Medigap plans, but, as discussed later, this appears to be due in part to overpayments from the Medicare trust fund. This does not mean that there is no potential for savings for Medigap from managed care, but it does suggest that HMOs will have to save money more by reducing services than by reducing the price they pay to doctors and hospitals. That being the case, it is particularly important to establish adequate safeguards to ensure that cost savings are not coming at the expense of quality.

In addition, affordability is a relative term. The problem of keeping Medigap premiums affordable is exacerbated by the high proportion of low-income elders. Nationally, 78% of Medicare beneficiaries have incomes below $25,000 (Twentieth Century Fund, 1995).

WHO PROVIDES MEDIGAP?

There are two basic types of private Medigap coverage: traditional fee-for service plans, also known as indemnity coverage, and managed care plans offered through Health Maintenance Organizations (HMOs). Medicaid, the federal/state health insurance program for the poor, fills in the gaps for elders who meet the income and asset eligibility standards.

FEE-FOR-SERVICE PLANS

Fee-for-service plans offered in Massachusetts include the Medex plans offered by Blue Cross and the plans offered by commercial insurance companies, such as Bankers Life. These plans allow subscribers to choose any doctor they want. Currently, three commercial insurance companies, plus Blue Cross, offer fee-for-service plans. As of May 5, 1997, prices for Medicare Supplement 2 ranged from $139.00 to $230.04 per month.

Table 2. Massachusetts Fee-For-Service Medigap Premiums.

Company	Core	Supplement 1	Supplement 2
Bankers Life and Casualty Co.	$53.08	none	$157.08
Blue Cross & Blue Shield of MA	$54.76 (Medex Core)	$95.87 (Medex Bronze)	$230.04 (Medex Gold)
Hartford Life Insurance Co.	$41.00	$74.00	$139.00
Prudential-AARP	$47.00	$89.25	$201.25

Notes:
1. Hartford is only available to retired military personnel
2. Prudential-AARP is only available to AARP members.

Unlike Supplement 2, there is relatively little price variation among Core and Supplement 1 products. Core is a new product that has only been sold on the basis that all applicants must be accepted. Therefore, the rates for Core do not reflect the historic differences between Blue Cross and other insurers. The variation that does exist is probably due as much to normal variation in a small pool of enrollees (Blue Cross, the largest Medigap insurer, has only 1,172 people enrolled in Core) as to any other factor. The lowest cost Core supplement available to the general public is 86% of the price of the most expensive Core plan. For Supplement 1, the lowest cost plan is 93% of the highest cost, but for Supplement Two the lowest cost plan is only 68% of the highest cost (since Bankers Multiple is requesting such a large increase, it seems likely that their low price for Supplement 2 is an anomaly and therefore the ratio was calculated using the next lowest premium).

The Massachusetts Medigap reform law (Chapter 176K, which will be discussed later) required all plans to accept all applicants regardless of health status. As a result, the price difference among insurers is shrinking. However, as prices rise overall, more elders -- and particularly healthier ones -- are making the choice to give up prescription drug coverage. This division of healthier and sicker groups into different plans is known as "risk selection." As a result, the price difference between Supplement One and Supplement Two is growing. The average monthly differential for prescription coverage in the indemnity market is $103.56. In 1991, the premium for Medex II (Bronze), which did not cover prescription drugs, was 62.6% of the Medex Gold premium. Today the comparable product costs only 42% of the Medex Gold premium.

In other words, coverage that includes prescription drugs is becoming relatively more expensive. This is true not only because of the rising cost of prescription drugs themselves, but because a larger percentage of those opting for prescription drug coverage are likely to have higher physician and hospital costs as well. Based on the price differential of prescription and nonprescription coverage for Medicare HMOs, as illustrated in the next section, we can expect a similar dynamic to occur in the HMO market.

MEDICARE HMOs

Unlike traditional Medigap coverage, which allows a subscriber to consult any physician that he or she chooses, Medicare HMOs require subscribers to receive most of their medical care from a limited list of participating providers. In exchange for this reduction in choice, these HMOs typically offer Medicare beneficiaries some combination of enhanced benefits and lower premiums.

Currently, five companies are offering Medicare HMO coverage in Massachusetts (Blue Cross/Blue Shield would make six but sale of their

Medicare HMO has been temporarily suspended by the federal government). All HMOs are required by Massachusetts law to offer a plan covering prescription drugs. A number of HMOs also offer an option without prescription drug coverage for no premium. These plans take the monthly payments they receive from Medicare as full premium. HMO plans are roughly comparable, but are not as standardized as fee-for-service plans. Typically, HMOs impose no deductibles and require limited copayments. HMOs vary not only as to whether they provide prescription drug coverage, but regarding the copayments for drugs and office visits. The average premium differential between prescription and nonprescription plans in the HMO market is $62 per month.

Table 3. Massachusetts Medicare HMO Policies.

Company	Plan	Monthly premium	Office visit copay	Prescription drug copay (outpatient)	Prescription drug copay (mail-order)
Fallon	Senior Saver	$0	$5	n/a	n/a
Fallon	Senior Preferred	$72.50	$5	$2 generic $5 brand	$2 generic $5 brand
Harvard Pilgrim	First Seniority	$0	$5	n/a	n/a
Harvard Pilgrim	First Seniority w/drug	$65	$5	30days, $5 90days, $10	30days, $5 90days, $10
Harvard Pilgrim	CarePlus	$65	$5	n/a	n/a
Harvard Pilgrim	CarePlus w/drug	$112	$5	30days, $5 90days, $10	30days, $5 90days, $10
Tufts	Secure Horizons	$0	$5	n/a	n/a
Tufts	Secure Horizons w/drug	$65	$5	$8 generic $15 brand	$4 generic $8 brand
United HealthCare	Medicare Complete	$0	$5	n/a	n/a
United HealthCare	w/deluxe rider	$46	$5	n/a	n/a
United HealthCare	w/drug rider	$124	$5	$10 all	n/a
United HealthCare	w/deluxe rider & drug rider	$170	$5	$10 all	n/a
U.S. Healthcare	Medicare Premier	$40	$2	n/a	n/a
U.S. Healthcare	Medicare Premier w/drug	$99	$2	$10 all	n/a

(continued next page)

U.S. Healthcare	Medicare V	$10	$5	n/a	n/a
U.S. Healthcare	Medicare V w/drug	$69	$5	$10 all	n/a
U.S. Healthcare	Medicare X	$0	$10	n/a	n/a
U.S. Healthcare	Medicare X w/drug	$59	$10	$10 all	n/a
HMO Blue	Blue Care 65 Value	$0 to $30	$5	n/a	n/a
HMO Blue	Blue Care 65 Value Plus	$65 to $95	$5	Health Ctr $5; Retail $8 generic, $15 brand	$5 generic $10 brand

Notes:
1. Office copayments for US Healthcare are for primary care physician visit.
2. HMO Blue could not be offered as of March 8, 1996 because of federal HCFA intermediate sanctions.

In addition to the benefits varying more under Medicare HMOs than fee-for-service plans, the premiums for coverage with prescription drugs are also more variable. The low premium for top of the line coverage is $65 per month while the high premium is $170 per month.

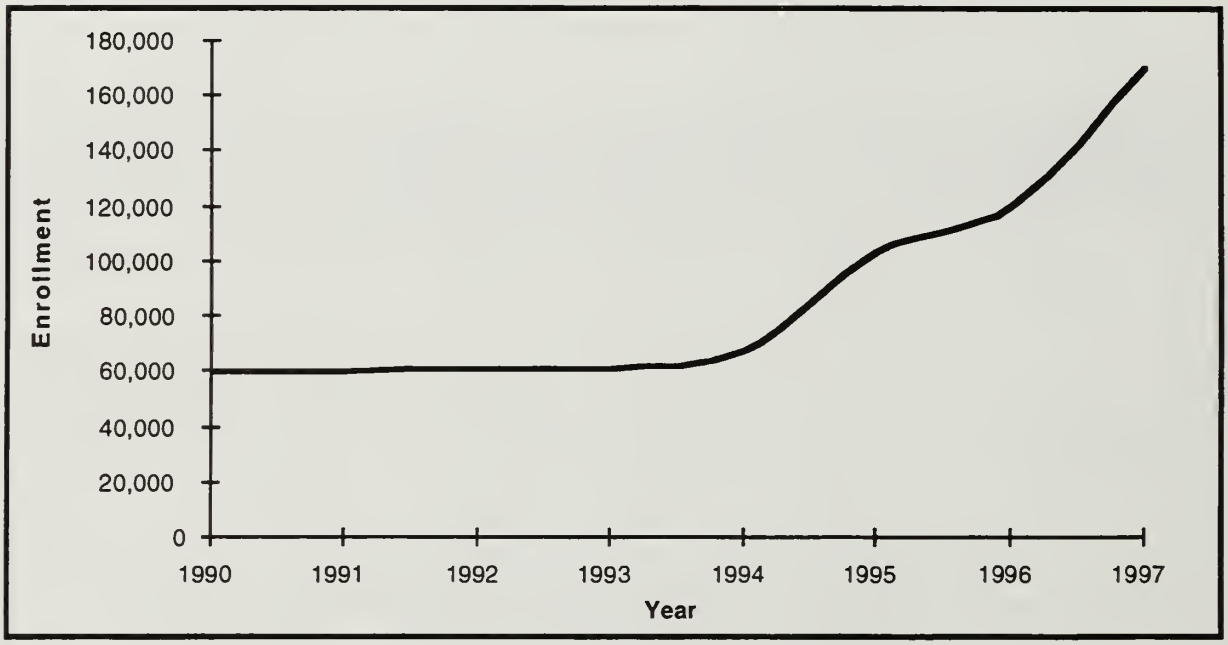
The average HMO premium for top of the line coverage is $91.55 and the average fee-for-service premium is $181.84. In 1991, Medex III (Gold) cost $91.97. After taking inflation into account, a Medicare HMO with prescription drug coverage is cheaper today in real dollars than was Medex Gold in 1991. A person switching from Medex III to a Medicare HMO with prescription drug coverage would receive roughly comparable coverage with a decline in real cost. However, it is likely that Medicare HMO premiums are artificially suppressed and that prices will rise somewhat in the near future as the Health Care Finance Administration adjusts the payment formula to more accurately reflect the enrollee population (see Figure 2).

HMO ENROLLMENT IS GROWING RAPIDLY

In 1990, roughly 60,000 Medicare beneficiaries were enrolled in HMOs, a decline of 5,000 from the previous year. By 1994, this number had grown to only 62,000. In 1995, enrollment jumped to 104,000, by April 1996 had reached 121,000, and by March of 1997 reached 170,107. It is difficult to pinpoint a specific reason why HMO enrollment suddenly took off. It is probable that three factors are largely responsible. The continued price escalation in the traditional Medigap market created more willingness among elders to explore alternatives. At the same time, the marketing success of Medicare HMOs, and particularly of

"no premium" options in other parts of the country likely encouraged Massachusetts HMOs, many of whom had negative experiences in the Medicare market, to try again (Massachusetts was unusual as a state with high HMO penetration in the under age 65 market, but low Medicare HMO enrollment). Finally, Medicare reimburses HMOs in Massachusetts at a relatively generous level, which further encouraged HMOs not only to offer but to aggressively market their plans to Medicare beneficiaries.

Figure 2. Upward Enrollment in Medigap HMOs.



HMO PROS AND CONS

The growth of Medicare HMOs offers Massachusetts elders a number of benefits and, at the same time, creates new problems for the Medigap market overall and for Medicare itself. Of particular concern is the tendency of HMOs to attract enrollees who are, on average, healthier than the Medicare population as a whole.

Without a doubt, the biggest advantage of Medicare HMOs is that they offer elders a lower-cost way of filling some of the gaps in their Medicare coverage. In some instances, HMOs offer benefits that are better than those available in traditional fee-for-service Medigap. For example, some HMOs will cover skilled nursing facility days without first requiring a three-day hospital stay. For elders who might otherwise be without Medigap coverage entirely, a no-premium HMO makes primary care more available and affordable. Also, HMOs are administratively simpler, requiring little or no paperwork.

On the other hand, HMOs place limitations on the choice of providers, and may require changes in the doctor-patient relationship that may come along with the lower premiums. In general, HMOs require their enrollees to receive all care from a specific list of providers. In some cases, the providers approved by the HMO may not be those most convenient to enrollees. Controlling the provider network is one way HMOs can make a plan more or less attractive to a particular community, encouraging some elders and discouraging others from joining. HMOs may also place restrictions on the ability of subscribers to consult specialists. Making access to specialists more difficult may discourage sicker elders from enrolling.

The methods some HMOs use to pay physicians gives those physicians a financial incentive to avoid sicker patients, or at least to encourage those patients to stick with the traditional fee-for-service system. This method of payment -- known as capitation -- gives doctors a fixed monthly sum per patient regardless of how many or how few services a patient uses. If a patient is a heavy utilizer, the physician loses money, while if few services are needed, the physician makes money.

Finally, HMOs may influence enrollment through their marketing practices. Targeting outreach and advertising to some communities and not others, holding enrollment events in places that are not handicapped or public-transportation accessible, and subtly (or not subtly) encouraging people with multiple health needs to look elsewhere are all techniques that can be used to skew enrollment.

In addition to skewing enrollment, incomplete or inaccurate marketing can lead to problems: people may enroll without understanding the HMO's practices or limitations. They may then become dissatisfied with their care and drop Medigap coverage. Although those who disenroll between open-enrollment periods can regain their regular Medicare coverage, they will not be able to purchase Medigap coverage until the next annual open-enrollment period.

How common Medicare HMO marketing abuses are in Massachusetts is not known. The quality of care provided is also unknown and hotly disputed. While some physicians and advocates argue that improved access to primary care and better benefits make Medicare HMOs a superior choice for elders, a recent study published in the *Journal of the American Medical Association* suggests that elders and low-income people who have serious health conditions do worse in HMOs than in fee-for-service plans (Ware, 1996)

Medicare pays HMOs in several different ways. The most common arrangement is called a "risk contract." Under a risk contract, an HMO receives a fixed payment per beneficiary from Medicare and must agree to cover all Part A and Part B services (typically HMOs will offer broader benefits than Medicare).

Medicare pays the HMO 95% of the average cost per beneficiary, adjusted for age, gender, and place of residency. It is widely agreed that Medicare is overpaying HMOs. As described above, HMOs have a variety of means of discouraging high-cost enrollees. It appears that these methods are in fact used, at least partially successfully. Several studies have concluded that the Medicare risk adjustments do not accurately reflect the true cost of serving the enrolled population. Instead of saving 5%, Medicare is paying nearly 6% more than would have been the case if HMO enrollees had stayed in traditional Medicare (Center for Studying Health System Change, 1996).

As a result of overpayment by Medicare, HMO premiums are artificially low. HMOs are able to offer more benefits at lower rates, which makes HMO plans look more attractive while at the same time hastening the bankruptcy of the Medicare Trust Fund (and, ironically, fueling the call for more managed care in Medicare). Similarly, by pulling healthier elders out of the traditional Medigap market, HMOs fuel the rise in traditional Medigap premiums.

CHAPTER 176K, THE MEDIGAP REFORM LAW

In 1994, Massachusetts adopted new legislation regulating the Medigap market, Chapter 176K, which changed the playing field for all Medigap insurers. Chapter 176K contains a number of important provisions.

- **Guaranteed issue.** All insurers offering Medigap policies must abide by a standard set of rules. Previously, most insurers were free to reject applicants. Today, Blue Cross is no longer the insurer of last resort. All insurers who sell individual Medigap insurance in Massachusetts must take any eligible applicant regardless of age or health.[1]

- **Community rating.** Insurers must charge all enrollees the same premium with the following exceptions: insurers are allowed to vary premiums based on the part of the state in which the subscriber lives (currently, no indemnity plans use geographic variation, but several HMOs do, related to the difference in payment they receive from Medicare). This is known as community rating. Insurers are also allowed to reduce premiums by up to 15% for three years for people who enroll when they first become eligible for Medicare and, beginning in 1997, to apply 15% surcharges for three years to people who upgrade their coverage. The surcharges are meant to discourage people from opting for plans without prescription drug coverage until they get sick and then switching into the more comprehensive plan so that this expensive care is covered.

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[1]Prudential/AARP sells Medigap insurance only to AARP members. However, anyone in Massachusetts over age 50 can become a member of AARP.

• **Standardized plans.** If there are too many different plan options, it is very difficult for consumers to compare plans and determine which ones are offering the best values. Furthermore, multiple plans mean that the risk pool is broken up into small fragments. This increases the problem, already occurring, of concentrating the sickest people in the most comprehensive plans.

Massachusetts allows three standard policies. All indemnity insurers must offer Medicare Core and Medicare Supplement 2. All HMOs must make available a plan that covers prescription drugs. The weakness of the existing standard benefit packages is that, as just discussed, they encourage the division of the Medicare population into two distinct groups, which makes coverage for less healthy elders prohibitively expensive.

• **Minimum loss ratios.** Insurers must spend at least a certain portion of their premiums on benefits. Currently, all plans are operating at or near their minimum. The minimum required percentages are:

- Blue Cross 90%
- HMOs 80%
- Commercial Insurers 65%

• **Rate hearings.** Previously, other insurers had to file their rates with the Division of Insurance but did not have to go through a rate hearing process as did Blue Cross. Under 176K, any insurer who files for an increase of 10% or more must go through a hearing.

Unfortunately, consumer organizations lack the resources to effectively monitor and intervene in the hearing process. Although the Attorney General and the State Rating Bureau intervene on behalf of consumers, there is little direct involvement by organized senior citizen groups themselves.

• **Open enrollment.** All plans must have an open enrollment period every February and March during which any Medicare beneficiary may enroll.

• **Restricted withdrawal from the market.** Insurance companies that sell Medigap insurance cannot leave the Massachusetts market without giving their subscribers a chance to enroll in another Medigap plan.

• **Public hearing.** There is an annual public hearing on the state of the Medigap market. The goal of this hearing is to "improve access, to encourage aggregation of risk pools and to promote long term access by individuals to coverage through continued stability and financial viability." Unfortunately, the hearings are not well publicized or attended. Furthermore there is no ongoing data collection and reporting to determine what is really happening. Anecdotal information is presented at the hearing and has some usefulness.

HOW WELL IS REFORM WORKING?

When Chapter 176K was adopted, there was hope that it would halt the death spiral in the Medigap, and especially the Medex, markets. (An insurance "death spiral" occurs when healthier enrollees drop coverage because of rising prices, leaving behind a smaller pool of sicker subscribers whose higher average health care costs push premiums still higher, causing still more people to drop coverage, and so on.) Although the 1994 law has many desirable features, it has not (and will not) produce the desired results.

• **Open enrollment has not attracted many new applicants to other plans.** As our 1992 report noted, Medigap premiums, and particularly Blue Cross Medex premiums, were rising rapidly in the late 1980s. The Blue Cross population was older and sicker than that of other insurers. By opening up other plans, it was thought that the Blue Cross subscriber profile would improve because some of the high-cost cases would migrate to other plans and that competition among plans would help restrain prices. However, to date there is little evidence to support this hypothesis. When in 1994 the Commissioner of Insurance rejected a Blue Cross rate increase based on the above premise, the ruling was overturned by the Supreme Judicial Court due to lack of supporting evidence.

In fact, in the first two years of open enrollment, very few elders are taking advantage of the opportunity to enroll in fee-for-service plans other than Medex. According to industry reports, as of July 1996, Bankers Life had only 3,700 subscribers. With 35,000 subscribers, AARP has the second highest number of fee-for-service enrollees after Medex, but most of them are enrolled in plans that were offered for sale prior to reform and are no longer accepting new applicants.

The implication of the low enrollment figures in non-Medex plans is that, even if the Medex subscriber pool is divided among these other insurers and mixed with their subscribers, there are so few of these healthier subscribers that it will make virtually no difference in the overall price of the products. They would all cost roughly as much as Medex does now.

• **Insurers in the fee-for-service market are not competing aggressively for Medigap business.** Although the price of other fee-for-service Medigap plans is only a little lower than for comparable Medex products, the underlying medical costs incurred by enrollees in these non-Medex plans is much lower. Over 90% of Medex premiums go to pay for medical care, while only 65% of the premiums of commercial insurers reflect the actual cost of care. The balance is devoted to administration, marketing, and profit. If there were vigorous competition in the Medigap market, we would expect insurers to lower their profit margins in order to reduce prices and attract more subscribers. Instead,

they are charging the legal limit and keeping their prices as close to the Medex price as possible. (This practice is known as shadow pricing.)

• **Reform has not and will not solve the problem of the growing lack of affordability of comprehensive Medigap insurance.** As detailed later, the rate of premium growth since the 1992 report has continued unabated and reform has made no visible impact on that growth rate.

• **"Risk selection" is still rampant.** Prior to the passage of Chapter 176K, risk selection occurred primarily because most insurance companies refused to take sicker applicants, while Blue Cross was required to accept all applicants. Therefore, if a Medicare beneficiary was sick, that person would most likely subscribe to Medex. Now that all insurers must take all applicants, the choice of indemnity carrier is less significant. However, 176K has not eliminated risk selection by product line. Individuals who regularly need prescription drugs are the ones who select the more comprehensive coverage. As a result the risk pool for comprehensive coverage is continuing to erode. At best, 176K may have added a few years to the life of Medex Gold equivalents. Once the market has evened out, all carriers will face the same pressures and will join Blue Cross in their current effort to reduce the benefits and shift the cost of catastrophic illness back to the individual.

ENROLLMENT AND COST TRENDS

Elders may be insured either under group plans or nongroup plans. Group plans are available to seniors through a past or current employer or union, or through a member-based organization, such as the American Association of Retired Persons. Nongroup or individual plans are direct contracts between the individual and the insurer.

It is difficult to know precisely how many elders have Medigap insurance since there is no consistent collection of information showing the insurance status of the Massachusetts elderly population. However, we know that in 1990, 44.7% of elders who were eligible to purchase Medigap insurance (having both Medicare Parts A and B) had either an HMO (group or nongroup) or nongroup[2] Medex plan. Today that percentage has declined to 36%.

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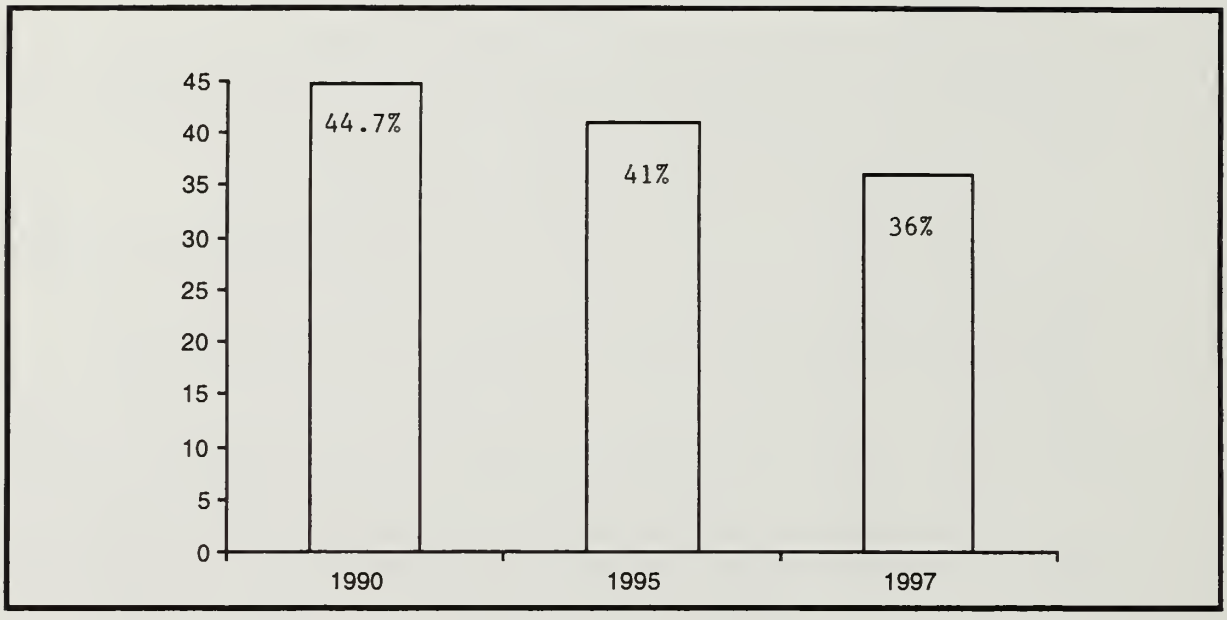
[2]For purposes of comparison to the 1990 report, only nongroup Medex plans are included in this calculation. It is worth noting that in group Medex plans, just as in nongroup Medex plans, enrollment percentages have fallen since 1990.

Figure 3. Percent of Elders Purchasing Nongroup Medex or HMO.



We know that HMO coverage has expanded to cover about 18% of the elderly population in Massachusetts, while the proportion covered by Blue Cross nongroup plans has declined. Erosion has been particularly dramatic in the Medex Gold line. The surge in HMO enrollment has roughly kept pace with the decline in Medex. However, because the number of Medicare beneficiaries is increasing, there are actually more elders without Medigap insurance today than there were in 1990. (The number of enrollees in group Medex has declined slightly and, as noted earlier there has been little enrollment in non-group commercial plans. There is no good data on the number of enrollees in group commercial supplements, but given the trend in group Medex, it is unlikely that there has been a significant enrollment surge in this section of the market.)

In 1990, the total combined enrollment in Medicare HMOs and nongroup Medex was 335,714. Of those, 275,392 were in Medex and 60,322 were in HMOs. Seventy-five percent of the Medex enrollees -- 200,284 people -- were enrolled in Medex Gold. As of March 1997, the combined Medex/HMO enrollment was 351,107. HMO enrollment had increased by nearly 200% to 170,107 while nongroup Medex enrollment had decreased by 66% to 181,000. Further, between 1990 and 1996 Medex Gold enrollment dropped by more than 50%.

Figure 4. Decline in "Medex Gold" Enrollment.

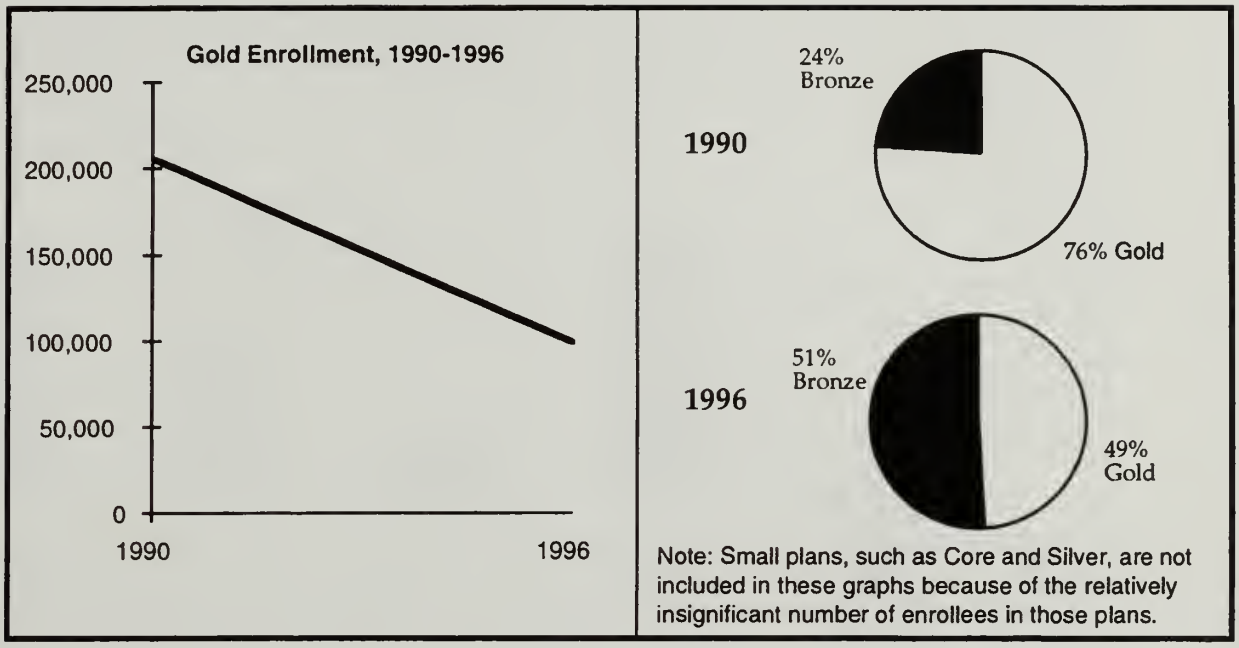
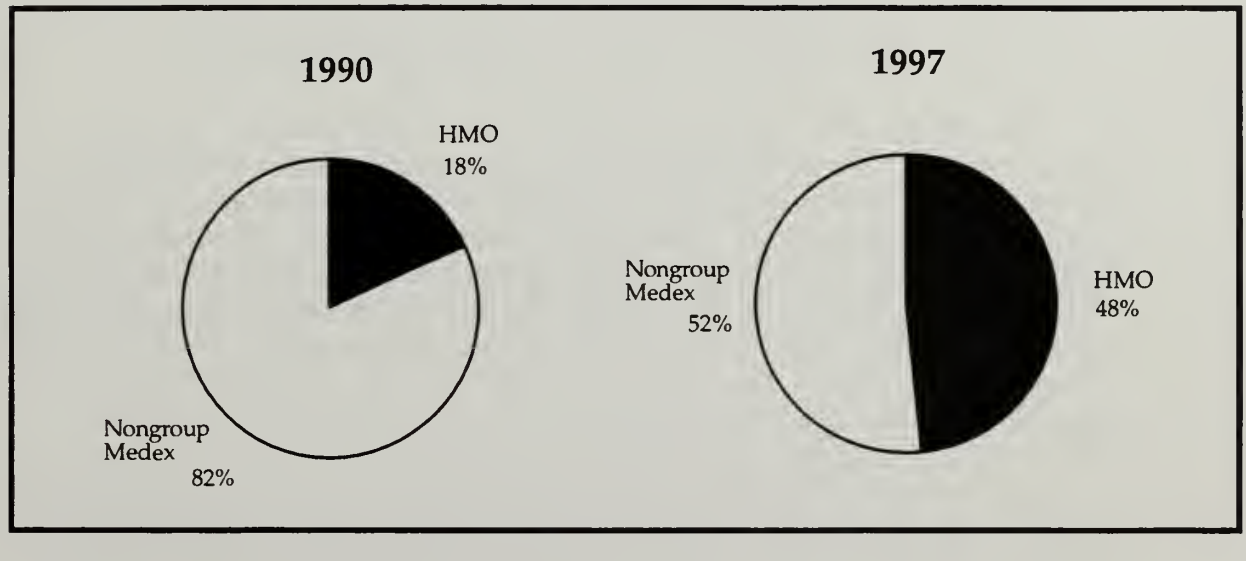


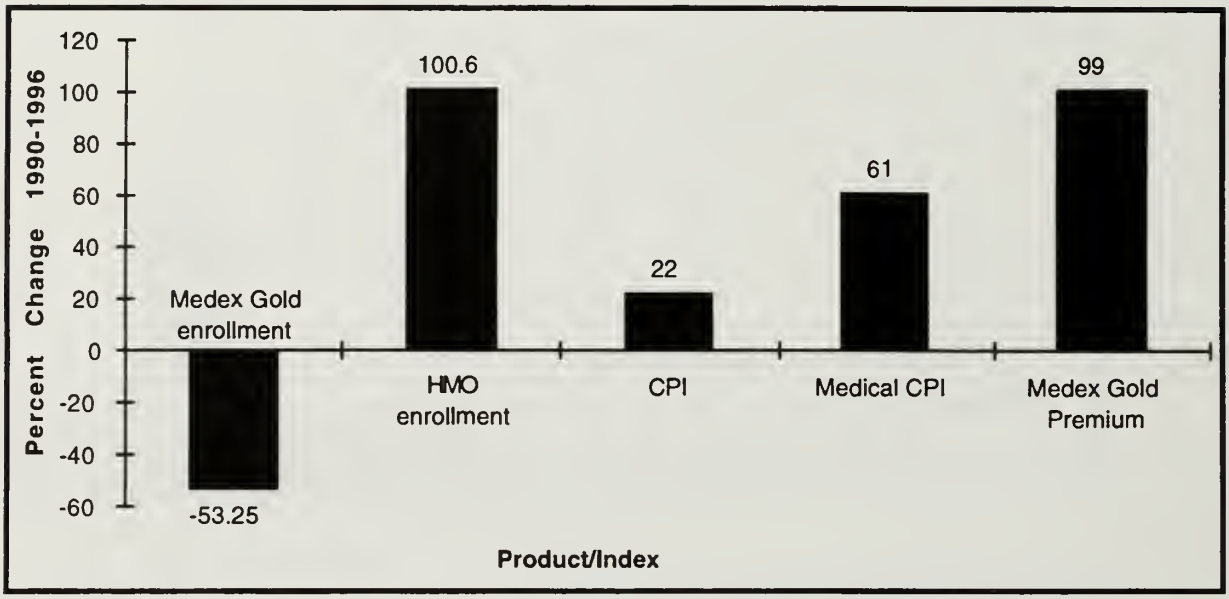
Figure 5. Shift in enrollment towards HMOs.



Between 1990 and 1996, Medex Gold premiums increased by 99%. Premiums increased by 112% over the previous five years. Over the same period, the Medicare Part A deductible increased by only 17%. HMO premiums also increased substantially, but far less than Medex. Harvard Community Health Plan's Medicare HMO increased by 60% since 1990, and Fallon's increased by 21.4%. The Consumer Price Index for all services (not including medical care)

increased by 22% from 1990 to 1996, while medical services grew at a 61% rate and prescription drug prices increased 32%.

Figure 6. Change in Medigap Plan Enrollment Versus Change in Consumer Price Index, 1990-1996.



NEW PHARMACY ASSISTANCE PROGRAM

In 1996, the Massachusetts Legislature enacted a prescription drug subsidy program for the elderly. Over the previous 10 years, elder advocacy groups had alternately pressed for a Medigap premium subsidy or a prescription drug subsidy program. The relationship between a prescription drug subsidy and Medigap is that drug costs represent a significant and rapidly growing part of the Medigap premium and, unlike physician and hospital care, are completely uncovered by Medicare. A prescription drug subsidy plan could allow low-income elders to either select a lower-cost Medigap plan without prescription coverage, or forego Medigap altogether.

However, limitations in the design of the Massachusetts prescription drug program make it unlikely that it will do more than provide a modest degree of assistance to those elders who have long since been priced out of the Medigap market.

Enrollment in the program is capped at roughly 60,000 enrollees and open enrollment coincides with Medigap enrollment, so an individual cannot make a decision about Medigap coverage based on his/her eligibility for the drug subsidy plan. This is an intentional feature of the program design to prevent people who now have prescription drug coverage from dropping it. However, it

requires those who have such coverage but cannot afford it to take a gamble. Preference is given to those with no Medigap whatsoever, so people seeking the prescription benefit must elect to go without Medigap coverage entirely, without even the certainty that they will actually be eligible for the subsidy. If they drop their Medigap coverage, they may find themselves ineligible for the drug program as well.

Income eligibility in the first year of the program was capped at 133% of the federal poverty line. This targeted benefits for those who needed them most, but left out many low-income elders who cannot afford Medigap. The program has been expanded to cover those who fall within 150% of the federal poverty line. Current legislation before the state Senate (S. 1938) can expand the program in future years to the extent that funds are available to cover elders with higher incomes, but it is likely that the 60,000 enrollment cap will be reached before the income guideline extends up to 200% of the federal poverty line.

Only maintenance drugs are covered. Although this does represent a large portion of elder prescription needs, it does leave some drugs out. Lastly, the program has a $500 annual cap per person. The cap means that many who receive the subsidy will still have significant unmet need.

In sum, the program will certainly be a help to low-income elders, but it does not really offer a solution to those for whom a comprehensive Medigap policy, including prescription coverage, is not affordable.

FUTURE OPTIONS

The current situation in the Medigap market is unstable and poses a danger to the viability of comprehensive coverage for Medicare enrollees. Rising prices, limited incomes, and the breakdown of the healthy and sick into separate risk pools spell the eventual demise of Medex Gold and similar products without action from the state or federal governments.

Some policymakers may feel that the type of coverage offered by Medex Gold is an anachronism in a health care system moving increasingly toward managed care. However, managed care is no panacea for the types of problems currently facing elders in need of health coverage. Not only are managed care prices suppressed by artificially high federal payment rates and younger, healthier subscribers, but there is every reason to believe that the risk selection issues in the fee-for-service market are replicating themselves in Medicare HMOs. In addition, concerns have been raised about whether the care provided in HMOs really is as good as fee-for-service care for certain high-risk elders (Ware, 1996).

Federal Changes

It is likely that federal changes in Medicare will have some spillover effect on the Medigap market. Congress may also make changes to the laws regulating Medigap insurance policies. However, not all of the changes under consideration would make comprehensive coverage more affordable. In fact, some would do the reverse.

Changes recently implemented, and some being debated, in Washington that may have a direct impact on Medigap include raising deductibles and coinsurance payments, moving home health coverage from Medicare Part A to Medicare Part B (thereby making it subject to 20% beneficiary cost sharing), greater reliance on managed care, the introduction of a voucher option (with Medicare contributing a defined amount of money instead of covering a specific set of benefits) and the introduction of Medical Savings Accounts (MSAs).

Raising deductibles and moving the home health benefit are straightforward cost shifts from Medicare to the elderly and would simply be reflected in higher Medigap premiums. The impact of the introduction of vouchers and Medical Savings Accounts is slightly less transparent, but each would be likely to make it more difficult for lower income and sicker elders to acquire comprehensive Medigap coverage.

Under a voucher program, elders would receive a voucher for a fixed amount of money and would then use it to purchase private insurance. The risk with a voucher program is that the growth in the value of the vouchers would not keep pace with rising costs. Instead, the burden of rising costs would be shifted away from the federal government and more fully onto the elderly. Healthier elders might compensate for the declining value of their voucher by buying less comprehensive coverage, while wealthier elders could make up the difference out of their own pocket. Those who needed more comprehensive benefits but could not afford the rising premiums would be stuck.

Medical Savings Accounts may exacerbate the problem of risk selection that is already plaguing the Medigap market. With MSAs, elders can elect to have Medicare purchase a catastrophic health policy with a high up-front deductible. The difference between the premium cost and the average cost per Medicare enrollee is deposited in an individual's MSA. If the cost of the catastrophic premium plus the amount that an elder draws from his or her MSA for out-of-pocket costs is less than the Medicare payment, the elder makes money.

MSAs are most likely to appeal to healthier and wealthier elders who would be more likely to make money with an MSA and for whom, in any event, the out-of-pocket costs of a catastrophic plan would not create a barrier to receiving care. For those low-income elders who might be tempted to gamble

with an MSA, the result could be unaffordable out-of-pocket costs, while those left in the traditional insurance market -- HMO and fee-for-service plans -- would see their premiums increase as healthier elders left the traditional market for MSAs.

Revisions in the HMO payment formula, to better reflect the true cost of serving enrollees, is also a possible change at the federal level. A reduction in federal payments would likely force HMO premiums upwards unless offsetting cost savings could be found. The increase in cost would reduce the incentive of elders to join HMOs. If fewer elders joined HMOs, there would probably be some lowering of fee-for-service Medigap prices, but, at the same time, some elders who are only able to afford low or no cost HMOs could be priced out of the market entirely. The federal (or state) government could also more closely monitor Medicare HMO marketing practices to make sure that no misleading marketing or cherry picking is occurring.

One step that Congress recently took was to require Medicare to pay 80% of the Medicare-approved outpatient hospital fee. Previously, individuals (or Medigap insurers) paid 20% of the hospitals' charges, which are typically higher than the Medicare-approved fee. Medicare paid the difference between the Medicare approved fee and the payment made by the individual. As a result, individuals and Medigap plans overpaid more than 20% of what the hospital actually received. Now that Medicare covers 80% of the approved amount, there should be a substantial cost savings to individuals and to Medigap plans.

State Action

One proposal to address the problem, offered as legislation for the Massachusetts Legislative 1997 session by Blue Cross/Blue Shield, was to lower prices by reducing benefits, particularly prescription drug benefits. This approach simply shifts the risk of illness back to the sickest individuals. Any savings produced by this approach would be ephemeral even for Blue Cross, since reduced access to prescription drug coverage is likely to result in worse health and increased hospital and other health costs. At the same time, Blue Cross proposed reducing their loss ratio from 90% to 65%, which would cancel out any savings to consumers. If such a proposal became law, Blue Cross subscribers would simultaneously see a cut in benefits and an increase in prices.

Another reform, also proposed by Blue Cross, would be to require a state-level risk adjustment among plans. Plans with healthier than average enrollees would pay into a pool and plans with sicker than average enrollees would be able to draw from it to reduce premiums. If such a program were in place, it would have the effect of reversing the federal policy change that required all plans to be rated separately. The difficulty of such an approach is that once the risk pool has broken down, as it has in Massachusetts, it cannot be put back together again without causing prices to rise for healthier elders.

RECOMMENDATIONS

The 1992 report prepared by Health Care For All for the Gerontology Institute found that growing lack of affordability of Medigap coverage by those who need it put this coverage at risk. Some combination of cost reductions and subsidies was needed to remedy this situation. Since then, some action has been taken on both fronts. HMOs are offering lower-cost options and the new prescription drug program offers a sort of indirect subsidy. However, neither is adequate. The number of elders without Medigap insurance is continuing to increase, and the risk pool is breaking down into distinct groups made up of the healthy and the sick.

The best solution to these problems, although it is not on the political map following the defeat of national health reform, would be to combine elders and younger people into one plan with premiums based on income. Short of that, a number of steps could be taken to make comprehensive Medigap insurance more affordable.

On the federal level, having Medicare pick up its fair share of outpatient costs should help reduce Medigap prices. Adjusting the payment formula to Medicare HMOs to better account for enrollee risk would reduce selection issues between fee-for-service and HMO plans but would also raise prices for some elders.

The state could apply some level of risk adjustment to the Medigap market to reduce the current problem of healthy and sick elders joining separate plans. Such an approach would work best if it was accompanied by a premium subsidy so that low-income elders would not face premium increases as a result of the risk adjustment.

State government could also make the Medigap drug benefit design and the prescription drug subsidy program work together to provide the best possible coverage. Under this approach, all plans, not just all carriers, would be required to offer prescription drug benefits, but some differences in the deductible would be allowed. A high-cost sharing plan could be dovetailed with a revised public-sector pharmacy benefit so that lower-income seniors could still obtain insurance and have prescription coverage, while higher-income elders could choose either a lower drug deductible or could afford to partially self-insure for the cost of prescription drugs. This reform could not be achieved without an additional expenditure of state funds, since it would require both an increase in the number of elders covered by Massachusetts's Pharmacy Assistance program, and an increase in the cost per beneficiary beyond what is currently being contemplated.

Unfortunately, all of the above reforms face serious political obstacles. Without a combination of political leadership and a high degree of unity and mobilization within the elder community, it is most likely that the current destabilization and breakdown of the Medigap insurance market will continue.

Improved monitoring of the Medigap market is also needed. To accomplish this a consumer task force or advisory board could be convened by the Attorney General's Office or the State Rating Bureau at the Division of Insurance. The Advisory Board would compile and report information on the Medigap market on a regular basis. Such information should, at a minimum, include enrollment trends, premium trends, and loss ratios. Information provided by the board could begin to call attention to the problems in the Medigap market, much as the trustees of the Medicare Trust Fund have called attention to the pending solvency problems of the Part A Trust Fund. A Medigap Advisory Board could also be a forum to discuss additional options for reform and begin to build political support for the necessary action by educating policymakers and the media.

CONCLUSION

The fundamental dynamic of elderly health care -- the reason why Medicare was created in the first place -- is that elders are a relatively high-cost but low-income population. Although many elders are well off, the majority live in quite modest circumstances. Without access to the level of subsidy typically provided by employers, most elders cannot self-finance their medical care.

Since the inception of Medicare, the growth in health care costs has outpaced the growth in elder income. As a result, even the gaps in Medicare coverage are now beyond the means of many elders to self-finance. As more and more elders find themselves unable to afford the price of comprehensive Medigap coverage, they will be forced to select less comprehensive options or drop their coverage entirely.

Medex Gold and similar plans will be purchased only by those elders who are wealthy enough to afford very high premiums. Although Medicare HMOs are a cheaper option, it is likely that their prices will increase, that benefits will go down, or that both may occur in the near future as Congress adjusts payment rates and older and sicker elders enroll. In addition, HMOs may not be a good choice for all elders. Recent research has sparked a controversy about whether the quality of care for sicker elders in HMOs is as good as in the fee-for-service system.

To prevent the breakdown of the Medigap insurance market and reverse the increase in the number of elders who lack comprehensive coverage, additional steps must be taken. Unfortunately, all reforms that might actually

address the problem face serious political obstacles. Without a combination of political leadership and a high degree of unity and mobilization within the elder community it is most likely that the current destabilization and breakdown of the Medigap market will continue. Building that leadership, unity, and commitment to action is, therefore, the immediate task at hand.

GLOSSARY

Capitation -- A method of paying physicians or other health care providers under which they receive a fixed amount per patient regardless of how many or how few services they provide.

Coinsurance -- The difference between what an insurance company pays for a service and the total approved price of that service. Often coinsurance is expressed as a percentage of the approved price.

Community Rating -- A method of determining the price of insurance under which all subscribers pay the same premium.

Death Spiral -- A process under which healthy people leave an insurance plan, which causes premiums to rise because the average enrollee now has higher medical bills, which causes still more people to drop out, which causes premiums to rise still higher, ultimately destroying the viability of that insurance plan.

Deductible -- An amount of money a subscriber must pay toward the cost of care before his/her health insurance begins to cover medical bills.

Fee-for-service -- A method of paying physicians and other providers under which the physician receives a payment based on each service he/she performs. Also a type of insurance plan that reimburses physicians in this manner.

Health Care Finance Administration -- The federal agency that administers the Medicare and Medicaid programs.

Health Maintenance Organization (HMO) -- A type of insurance that generally requires subscribers to receive their medical care from a defined group of service providers.

Indemnity -- Originally a type of insurance under which the insurer would pay a fixed monetary benefit for a claim (as opposed to a percentage of the claim). Now often used interchangeably with the term fee-for-service (see above).

Medex -- The brand name of Blue Cross/Blue Shield's Medigap insurance. Historically the most popular Medigap insurance in Massachusetts.

Medicaid -- A health insurance program for certain low-income people financed jointly by the federal and state government.

Medical Savings Account -- A tax-sheltered savings account, accompanied by a high deductible health insurance plan. Money from the savings account can only be withdrawn to pay for medical expenses.

Medicare -- Federal health insurance program for the elderly, people with disabilities, and people with end-stage renal disease, financed by a combination of payroll taxes, general revenues, and enrollee premiums.

Medicare Trust Fund -- The federal account, funded by payroll taxes, which finances expenses from Medicare Part A.

Minimum Loss Ratio -- The minimum percentage of premiums an insurer is required to spend on paying for health benefits as opposed to the percentage allocated to overhead and profit.

Risk Adjustment -- The practice of adjusting payments to an insurer or a physician group to reflect the anticipated costs of the enrollees.

Risk Contract -- A contract between Medicare and an HMO under which the HMO agrees to provide all Medicare services for a fixed amount per enrollee.

Risk Pool -- The enrollees in any given insurance plan.

Risk Selection -- A process under which healthier and sicker people are divided into separate insurance plans. (The opposite of risk pooling, where the healthy and sick are combined into one plan.) Risk selection can be a deliberate strategy of insurers or can result from the choices made by healthier individuals, or both.

Skilled Nursing Facility -- A health care institution (generally a nursing home, but sometimes a hospital unit) licensed to provide a level of services reimbursable by Medicare.

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NOTE: Data on the number of Medicare beneficiaries in Massachusetts is from the Health Care Finance Administration (HCFA) *Annual Beneficiary Report*, Baltimore, MD. The basic overview of the Medicare program is from the *Medicare Hand Book* also published by HCFA, with updated cost sharing information from the Federal Register. Enrollment data on Medigap plans is drawn from reports filed with the Massachusetts Division of Insurance. HMO enrollment is drawn from quarterly reports compiled by the Massachusetts Hospital Association and from HCFA data. The discussion of the special difficulties faced by Medigap plans attempting to control costs is drawn in part from *Are Private Insurers Really Controlling Spending Better than Medicare?*, by Marilyn Moon and Stephen Zuckerman (Kaiser Foundation). An overview of the evidence on risk selection within the Medicare HMO market is available in "Issue Brief Number 4" from the Center for Studying Health System Change. Quality concerns related to Medicare HMOs were reported in the October 2, 1996 edition of the Journal of the American Medical Association. Helpful background may also be found in *Medicare Reform* (Twentieth Century Fund) and in the Summer 1996 edition (Volume 20, Number 2) of *Generations*.

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THE GERONTOLOGY INSTITUTE

University of Massachusetts Boston

The Gerontology Institute at the University of Massachusetts Boston addresses social and economic issues associated with population aging. The Institute conducts applied research, analyzes policy issues, and engages in public education. It also encourages the participation of older people in aging services and policy development. In its work with local, state, national, and international organizations, the Institute has four priorities: 1) productive aging, that is, opportunities for older people to play useful social roles; 2) health care for the elderly; 3) long-term care; and 4) economic security for older people. The Institute pays particular attention to the special needs of low-income and minority elderly.

Established in 1984 by the Massachusetts Legislature, the Gerontology Institute is a part of the University of Massachusetts Boston. The Institute furthers the University's commitment to the study and development of social policy on aging, and it supports its educational programs in Gerontology, which are in the College of Public and Community Service. One of these is a multidisciplinary Ph.D. program in Gerontology. Through participation in Institute projects, doctoral students have the opportunity to gain experience in research and policy analysis. Institute personnel also teach in the Ph.D. program.

The largest of the educational programs is the Frank J. Manning Certificate Program in Gerontology, which prepares students for roles in aging services. Most students are over 60 years of age. Each year the Institute assists this program in conducting an applied research project in which students administer a large telephone survey. An advanced certificate program is also supported by the Institute; its in-depth courses focus on specific policy issues.

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Core funding for the Gerontology Institute is provided by the Massachusetts Legislature. Major projects are funded through grants and contracts.

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